

**LEA Medi-Cal Billing Option Program
Frequently Asked Questions (FAQs)**

****PLEASE REVIEW THE LEA MEDI-CAL BILLING OPTION PROVIDER MANUAL
FOR COMPLETE LEA PROGRAM AND POLICY INFORMATION****

Note: Italicized text indicates new and/or updated FAQs as of 06/23/10.

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I. General Program Requirements

Q1. Is there a booklet that explains the LEA Medi-Cal Billing Option? Do you send periodic updates to LEA providers regarding program changes?

- A. Yes, there is a specific portion of the Medi-Cal provider manual that explains the LEA Medi-Cal Billing Option Program. To obtain a copy, you can contact Electronic Data Systems (EDS) at 1-800-541-5555, or download an electronic copy on-line via the Medi-Cal website (www.medi-cal.ca.gov) or on the LEA Program website (<http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>). Updates to the Medi-Cal provider manual are automatically sent to all enrolled LEA providers; other parties may request to receive provider bulletins and manual replacement pages by calling EDS at 1-800-541-5555.

Q2. Can private schools participate in the LEA Medi-Cal Billing Option Program?

- A. Private schools do not qualify as LEA providers. However, the Individuals with Disabilities Education Act (IDEA) 2004 does include provisions to ensure that students in private schools have access to special education services. For example, in certain cases a student may receive services at the public school district where the private school is located. According to California Education Code, Sections 56170 - 56177, a public agency must administer funds and property used to provide special education and related services.

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Q3. How do I update my LEA address or contact information?

- A. If you wish to submit a change of physical address, a new LEA Provider Participation Agreement must be submitted to the California Department of Education. If you wish to submit a change of billing and/or mailing address, please submit a DHCS 6209, Medi-Cal Supplemental Changes Form to the Provider Enrollment Branch. Both of these forms can be obtained by visiting the LEA Medi-Cal Billing Option Program Website.
<http://www.dhcs.ca.gov/provgovpart/Pages/LEAContactInformationForm.aspx>

Q4. What is the due date for the Annual Report?

- A. The Annual Report must be submitted to the California Department of Health Care Services (DHCS) by October 10 of each year, as required in the LEA Medi-Cal Billing Option Provider Participation Agreement. Continued enrollment in the program is contingent upon submission of the Annual Report. If you have questions regarding the report, please contact DHCS, Provider Enrollment Branch at (916) 323-1945. The Annual Report is available on the LEA Program website at <http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>.

Q5. Are there any guidelines available on patient confidentiality?

- A. All medical records under this program are confidential and cannot be released without the written consent of the beneficiary or his/her personal representative. According to State Medi-Cal regulations, information can be shared or released between individuals or institutions providing care, fiscal intermediaries, and State or local official agencies. However, the Family Educational Rights and Privacy Act (FERPA) require that schools obtain written consent from the parent or guardian prior to releasing any medical information in personally identifiable form from the student's education record.

Confidentiality requirements are based on the following Federal and State codes and regulations:

1. 42 U.S. Code Section 1320c-9 and 20 U.S. Code Section 1232g (www.gpoaccess.gov/uscode/index.html);
2. 42 Code of Federal Regulations, Section 431.300 and 34 Code of Federal Regulations, Part 99 (www.gpoaccess.gov/cfr/index.html);
3. California Code of Regulations (CCR), Title 22, Section 51009 (www.ccr.oal.ca.gov);
4. Welfare and Institutions Code, Section 14100.2 (www.leginfo.ca.gov/calaw.html);
5. California Education Code, Section 49060 and 49073 through 49079 (www.leginfo.ca.gov/calaw.html).

Q6. Does the local match requirement have to be service specific (i.e., local funds paid for the specific service) or does it apply to the overall reimbursement (i.e., local funds/expenses are equal to/greater than the total federal reimbursement)?

- A. The local match is not service specific. LEA providers can not use federal funds to match other federal funds. On an annual basis, LEA providers certify that they match the 50% local portion with non-federal funds.

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Q7. Are there regulations stipulating that a billing vendor may not be paid on a percentage basis?

- A. In the March 2009 provider training sessions, Audits and Investigations personnel cited the following regulations:

California Code of Regulations § 51502.1. Requirements for Electronic Claims Submission.

(a) As used in this section, the following definitions shall apply:

(1) "Biller" includes any employee, officer, agent or director of the entity which will bill on behalf of a provider pursuant to a contractual relationship with the provider which does not include payment to billers on the basis of a percentage of amount billed or collected from Medi-Cal.

In addition, the Code of Federal Regulations, Title 42: Public Health, includes detail on payments made to business agents:

PART 447—PAYMENTS FOR SERVICES

Subpart A—Payments: General Provisions

§ 447.10 Prohibition against reassignment of provider claims

(f) Business agents. Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is—

- (1) Related to the cost of processing the billing;
- (2) Not related on a percentage or other basis to the amount that is billed or collected; and
- (3) Not dependent upon the collection of the payment.

Q8. Can school districts spend a portion of their Medicaid reimbursements for overhead/indirect cost?

- A. According to the LEA Medi-Cal Billing Option Provider Participation Agreement, federal funds received by an LEA provider for LEA services shall be reinvested to provide health and other support services for school children and their families. LEA providers may also spend a portion of the Medicaid reimbursements to cover:
- LEA administrative, preparation and submission costs related to filing Medi-Cal claims;
 - LEA support staff costs for program coordination and facilitating the collaborative process.

II. Eligibility

Q9. Can we check eligibility with a student's SSN?

- A. Currently, you can still verify eligibility using SSN via the Memorandum of Understanding. However, this may change in the future due to HIPAA requirements.

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Q10. When my LEA verifies eligibility on the internet, do we need to have the student's Beneficiary Identification Card (BIC) number to check eligibility?

- A. Yes; however, if you don't have the student's BIC number, you can use another eligibility determination method, such as the Memorandum of Understanding or the LEA Tape Match option. Refer to the LEA Medi-Cal Billing Option Provider Manual located for additional eligibility information.

Q11. Does a Medi-Cal eligible student have continuing coverage or is there a limit on total funds for each recipient's health coverage?

- A. Eligibility is determined on a monthly basis by the county. There is no limit on funds for each recipient's health coverage. The period of eligibility for Medi-Cal persons shall continue through each successive month during which the person is determined to be eligible. (Title 22, CCR, Section 50195)

Q12. Medi-Cal eligibility for students can only be determined quarterly through the DHCS Information Technology Services Division (ITSD) data layout. Is there a way to determine eligibility on a monthly basis?

- A. Yes, there are several different ways to determine eligibility on a monthly basis. These methods include a Memorandum of Understanding (MOU) with the local county welfare department, Point of Service (POS) device, Automated Eligibility Verification System (AEVS), and the Medi-Cal website. These options are defined in the LEA Medi-Cal Billing Option Provider Manual located on pages 2 and 3.

Q13. What happens if my LEA loses its PIN number for the online eligibility verification option?

- A. You may go to the Medi-Cal Website at www.medi-cal.ca.gov, select the Provider Enrollment link, and download the application under the "Forms" Section. Your LEA will need to complete a new application and note that a confirmation of the existing PIN is needed.

Q14. How can I obtain a student's Medi-Cal Beneficiary Identification Card (BIC) number?

- A. The student's BIC contains the 14-digit alphanumeric BIC number. However, if the card is not available, your LEA can obtain the BIC number using the LEA Tape Match system or a Memorandum of Understanding (MOU) with the county welfare department.

Q15. Can a Medi-Cal eligible student who is enrolled in a school district or receives home schooling receive LEA services from another school district?

- A. Yes. A Medi-Cal eligible student may receive LEA services from another school district as long as the student is enrolled in a school district in California. Students receiving home schooling are enrolled in a school district. (Title 22, CCR, Section 51190.1)

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Q16. *Many students do not have Medi-Cal coverage when we claim costs related to their services, what could be causing this?*

- A. *The main reason why these students do not have coverage when LEAs bill for direct medical services is the delay between the date of service and date of claim for payment. The reason that this can be a problem is that Benefits Identification Card (BIC) numbers for students can change quickly. Students often get a Temporary Identification Number (TIN) to replace their BIC and when this is the case LEAs will not be able to bill claims. Our advice is as follows:*
- *Request BIC numbers based on date of service.*
 - *Bill for services as close to the date of service as possible.*
 - *If claims get rejected, LEAs should keep attempting to bill for the same student as they may become Medi-Cal eligible at a later date.*

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III. Assessment Policy and Billing

Q17. When an IEP/IFSP health assessment takes more than one day to complete, should we bill for a new assessment each day or for one assessment over the course of two days?

- A. For IEP/IFSP encounter-based assessments (physical therapy, occupational therapy, speech-language, audiological, health, and psychological), you will bill only one unit of service regardless of the amount of time it takes to complete the assessment. When billing for an assessment that takes multiple days to complete, use the “from-through” billing method to record the dates over which the assessment was conducted. If the assessment is completed on a single day, the “from-through” billing method is not required and LEAs may record the date of service on which the assessment was completed. The encounter-based rate has been developed to incorporate, among other tasks, preparation time, direct service time, and report writing time that occur over the course of the assessment, whether the assessment takes one day or several days to complete.

Q18. For our IFSP students (birth to age three), we do the initial, annual and a six-month/periodic review, as required by law. How do we bill for these services within the new program structure?

- A. The new structure allows for three types of assessments: initial/triennial, annual and amended.
- Initial/triennial assessments may be billed once every third fiscal year;
 - Annual assessments may be billed in the year when an initial/triennial is not performed; and
 - Amended assessments may be billed when performed to amend an initial, triennial or annual assessment that was performed in that fiscal year.

In this example, the six-month assessment would be considered an amended assessment.

Q19. How do we bill for services required to be delivered per the IEP? For example, if the IEP calls for quarterly vision or hearing assessment of a student, can these services be billed as treatment services, assuming the LEA meets the minimum time increments?

- A. No. Only one follow-up assessment is billable per fiscal year. In this case, your LEA could bill the first re-assessment as an amended assessment in addition to the initial/triennial/annual assessment conducted that fiscal year. The remaining quarterly assessments would not be billable, based on the new utilization controls.

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Q20. When conducting an annual assessment, certain information comes from the parent, and not necessarily from contact time with the student. Is this billable as an annual assessment?

- A. No, parent/guardian meeting time alone is not billable as an annual assessment. Required components of an annual assessment include:
- Review student records, such as cumulative files, health history, and/or medical records;
 - Interview student and/or parent/guardian;
 - Observe student in appropriate settings; and
 - Write a report to summarize assessment results and recommendations for LEA services.

During an annual assessment, administration and scoring/interpreting of tests may or may not be included, depending on the needs of the student. However, direct student contact service time is required. In addition, documentation is required to support that you have met the requirements of the assessment.

Q21. Which assessments can utilize the rounding policy?

- A. You cannot round up time spent to conduct assessment services. Assessments may only be billed for completed service time. The rounding policy applies to treatment services that are:
- Billed in 15-minute increments (nursing, trained health care aide and TCM services); or
 - Additional 15-minute increments provided beyond the initial 15-45 minute treatment session (physical therapy, occupational therapy, individual and group speech therapy, audiology, and individual and group psychology and counseling).

Q22. If a registered credentialed school nurse performs a hearing screening as part of a health assessment, can it be billed separately?

- A. All of the tests and procedures that are performed by a registered credentialed school nurse as part of a health assessment are reimbursable under one procedure code and maximum allowable rate. Under the new program structure, LEAs cannot bill for separate assessment components.

Q23. If an IEP student receives an initial speech assessment in English and a second speech assessment in Spanish, can both assessments be billed as initial assessments under the LEA Program? What if two practitioners perform the initial assessment?

- A. No. Initial and triennial IEP/IFSP assessments are limited to one every third fiscal year per provider per assessment type. This means that if more than one initial/triennial speech assessment is billed under your LEA's provider number before the third fiscal year, the second claim will be denied.

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IV. Treatment Service Policy and Billing

Q24. For non-IEP/IFSP students, can we bill the LEA Program for services rendered under a Section 504 Plan?

A. No. You may not bill Medi-Cal for services provided under a Section 504 Plan.

Q25. Can the assessment activity used for Section 504 Plan determination be billed to Medi-Cal as an initial assessment?

A. No. A Section 504 Plan determination is not equivalent to an IEP/IFSP determination under the LEA Medi-Cal Billing Option Program. LEAs may not bill Medi-Cal for services provided under a Section 504 Plan.

Q26. There is an annual service limitation of 24 services per 12-month period for non-IEP/IFSP services. If we transport a student to a therapy service, does that transportation count as one of 24 services in a 12-month period?

A. Yes. Each non-IEP/IFSP assessment, treatment and transportation service is included in the 24 services per 12-month period limitation. In addition, Free Care requirements must be met in order to bill for non-IEP/IFSP services.

Q27. Does rounding for treatment services only apply to nursing and school health aide treatments?

A. The rounding policy applies to two billing increment scenarios: (1) Treatments and TCM that are billed in 15-minute increments (nursing, school health aide, TCM services); and (2) Additional 15-minute treatment service increments beyond the initial 15-45 minutes (physical therapy, occupational therapy, group and individual speech therapy, audiology, and group and individual psychology and counseling). The rounding policy does not apply to any assessment services.

Q28. If we have an aide who is constantly accompanying an IEP/IFSP student and assessing or monitoring their medical condition, can we bill for the time when the aide is not providing direct medical care? For example, if an aide accompanies a student who must be constantly monitored for suctioning, can this monitoring time be billed?

A. Yes, an LEA can bill for an IEP/IFSP student to receive constant monitoring as part of direct medical service if it is medically necessary and authorized in the IEP/IFSP.

Q29. Can nurses bill for immunizations, administration of medications, glucose monitoring or tube feeding?

A. Nursing services include preventive and medically necessary procedures provided at the school site that are authorized in the IEP/IFSP. School nurses may provide immunizations, administer medications, monitor glucose or tube feed. However, the service must be provided to a specific Medi-Cal beneficiary and take, at a minimum, at least seven or more continuous treatment minutes in order to be reimbursed by Medi-Cal as a nursing service. When these treatment services are provided to a non-IEP student, the Free Care requirements must be met.

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- Q30. Under nursing services, a student is often observed to determine whether they need a treatment service. After the treatment is provided, the student continues to be observed to assess whether the treatment was successful. For example, a nurse provides suctioning as authorized in the IEP/IFSP, and continues to monitor the student after the treatment. Can the observation time prior to and after the treatment be billed as part of the direct service time to meet the seven minute minimum time period?**
- A. Yes. Medically necessary observation of a student as part of a direct medical service may be billed.
- Q31. Is “observation only” of an autistic student billable under the LEA Medi-Cal program? The aide time is written into the student’s IEP.**
- A. No. Observation of an autistic student is considered a behavioral service and is not billable under the LEA Medi-Cal Billing Option Program. Trained health care aides may only provide medically necessary specialized physical health care services under the supervision of a licensed physician or surgeon, a registered credentialed school nurse or a public health nurse. “Observation” is not considered a specialized physical health care service.
- Q32. Under nursing services, do we need to have a frequency attached to the service in the IEP? Many times the nurses will provide services on an as-needed basis, which is reflected in the IEP. Is this acceptable?**
- A. Nursing services may be authorized on an as-needed basis in the IEP/IFSP, as appropriate to the diagnosis. For certain medical conditions, physicians may authorize that services should be provided as required or needed. As long as the LEA maintains documentation that as-needed services are medically necessary, these services may be billed to Medi-Cal.
- Q33. What constitutes a non-IEP/IFSP health education/anticipatory guidance assessment under the new program?**
- A. Health education/anticipatory guidance is preventative medical counseling and/or risk factor reduction provided to an individual/parent based on an evaluation of the individual’s needs, and provided as a direct face-to-face service. When this service is provided to a non-IEP/IFSP student, the Free Care requirements must be met.
- Q34. How do you bill medical counseling (previously billed as a health education/ anticipatory guidance service) for IEP/IFSP students?**
- A. Although there is no specific billing code for health education/anticipatory guidance provided to an IEP/IFSP student, medical counseling may be provided by an appropriate practitioner as a treatment service within their scope of practice. For example, if a school nurse is providing counseling on nutrition to an IEP student that has an eating disorder (and the counseling is included in the student’s IEP), this may be billed as part of the nursing treatment service.

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Q35. Is health education/anticipatory guidance reimbursable under the LEA Program if the service was provided by telephone?

- A. No. Health education/anticipatory guidance is preventative medical counseling and/or risk factor reduction provided to an individual/parent based on an evaluation of the individual's needs, and provided as a direct face-to-face service.

Q36. Group speech therapy and group psychology/counseling are currently billable services. Are there any other services billable in a group setting?

- A. No, speech and psychology/counseling are the only services that may currently be provided in a group setting.

Q37. Are there a maximum number of students for “group” treatments? Prior to July 1, 2006, a group was defined as two to eight students.

- A. To bill for group speech therapy or psychology and counseling services under the new national codes, a group must be two or more students, but not more than eight students.

Q38. If there are three students in the group therapy session that lasts for 45 minutes, do we bill 45 minutes for each Medi-Cal eligible student, or do we divide the total time of the session by the number of students and bill 15 minutes for each of the students?

- A. Under this scenario, the LEA should bill 45 minutes for each Medi-Cal eligible student who participates in the group therapy session. Under the new national billing code structure, LEAs will bill one unit of service for each completed 15-minute increment in the initial service session, up to a maximum of 45 minutes. In this case, the LEA will bill three units of group therapy (3 units x 15 minutes = 45 minutes) for each Medi-Cal eligible student in the group therapy session; all three units will be reimbursable under one initial service maximum allowable rate.

Q39. Are toileting, diapering and lifting reimbursable under the LEA Program if those services are documented as medically necessary in the student's IEP?

- A. Diapering, toileting and lifting are considered personal care services, which are not covered in California's Medicaid State Plan. Therefore, these services are not currently reimbursable under the LEA Program. Personal care services may not be billed as nursing treatment services under any circumstance, even if prescribed by a physician and included in an IEP.

Q40. Do nursing services have to be provided in continuous minutes?

- A. Nursing treatment services are billed in 15-minute increments. When seven or more continuous treatment minutes are rendered, a 15-minute increment can be billed. The minimum time (seven minutes) must be one continuous period and not made up of shorter time periods provided throughout the day and added together.

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Q41. When a billable practitioner provides consultative service to a Medi-Cal eligible student's teacher who will be performing the treatment under the practitioner's supervision, is the practitioner's time spent consulting the teacher a billable treatment?

- A. No, consultations with a Medi-Cal eligible student's teacher are not a covered service in the LEA Medi-Cal Billing Option Program. The reimbursement rates for treatment services already account for "preparation and completion activities." Accordingly, consultations are not separately billable in the LEA Medi-Cal Billing Option Program.

V. Prescriptions, Referrals, Recommendations and Protocol

Q42. Would an electronic version of a prescription, referral or recommendation be acceptable in place of a hard copy document?

- A. Electronic prescriptions, referrals or recommendations are acceptable only if there are processes in place to ensure that the prescription, referral or recommendation is provided by a valid, appropriate and qualified practitioner and includes an electronic signature. However, hard copies of these forms must be maintained for at least three years.

Q43. When the parent signs the parental consent portion of the Assessment Plan, is this form adequate to document a parental request for assessment services?

- A. No. A parent, teacher or school nurse request for assessment requires specific documentation of the observations and reason for the assessment. A parent signature on an Assessment Plan is not adequate documentation under the LEA Program requirements. LEAs may be able to modify documentation they currently use to incorporate the information required to bill Medi-Cal when a parent requests an assessment service.

Q44. Is there a required format for prescriptions, referrals or recommendations for assessment services?

- A. Although there is no mandated format for this documentation, minimum requirements have been established including:
- Prescriptions: school name; student's name; reason for assessment; parent, teacher or practitioner observations and reason(s) for assessment; signature of prescribing practitioner, and type of practitioner.
 - Referral: school name; student's name; reason for assessment; parent, teacher or practitioner observations and reason(s) for assessment; signature of referring practitioner, and type of practitioner.
 - Recommendations must include a written statement in the student's record including: parent, teacher or practitioner observations and reason(s) for assessment; signature of recommending practitioner, and type of practitioner.

Although minimum requirements have been established, your LEA should develop standards that ensure adequate documentation of medical necessity for services exists in your files.

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Q45. When can a physician-based standards protocol be used to establish medical necessity?

- A. A physician-based standards protocol may be developed by your LEA and used to document the medical necessity of speech and audiology treatment services to meet California State requirements that a written referral be provided by a physician or dentist prior to rendering speech and audiology treatment services. However, according to federal law (42 CFR 440.110(c)), a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice is required to document medical necessity of speech and audiology treatment services. LEAs must meet both State and federal documentation requirements. Physician-based standards protocol does not meet federal requirements for documenting medical necessity of speech and audiology treatment services. In order to meet federal documentation requirements, a physician or other licensed practitioner of the healing arts (i.e., licensed speech-language pathologist or licensed audiologist) must refer the student for speech and audiology treatment services.

Q46. Will DHCS provide the physician-based standards protocol cover letter for the LEA providers?

- A. No, your LEA must develop and maintain its own physician-based standards protocol. The protocol may only be used to meet State requirements documenting medical necessity for speech and audiology treatment services. The protocol does not fulfill federal requirements as defined in 42 CFR 440.110(c), and noted in the answer above.

Q47. Is it necessary to have a prescription, referral or recommendation from a health services practitioner to provide assessment services?

- A. The prescription, referral or recommendation for an assessment must be documented in one of two ways: (1) your LEA can obtain an individual written prescription, referral or recommendation from an appropriate health services practitioner; or (2) a referral by a parent, teacher or credentialed school nurse. Regardless of which option is used, the required documentation must be maintained in the student's files.

Q48. Can an occupational therapist prescribe treatment services based on his/her assessment?

- A. The occupational therapist conducting the assessment may determine the need for treatment services. However, State regulations require a written prescription by a physician or podiatrist, within the practitioner's scope of practice, to bill for occupational therapy treatment services in the LEA Program.

Q49. For IEP/IFSP students receiving treatment services, prescriptions, referrals and recommendations may be established in the IEP/IFSP. What does this mean?

- A. For treatment services, the appropriate health service practitioner(s) may record the prescription, referral and/or recommendation for treatment services directly in the child's IEP/IFSP or as a separate document that is attached to the IEP/IFSP.

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Q50. Can a registered credentialed school nurse self-refer a student for a health assessment?

- A. Yes, a registered credentialed school nurse can self-refer, since they are one of the qualified practitioners listed to refer for assessment services. If a self-referral is made, the practitioner must still include the appropriate documentation in the student's file, including: observations and reason(s) for assessment, and the signature and practitioner title of the registered credential school nurse that is self-referring the student for the assessment.

Q51. How long is a prescription/referral/recommendation for treatment services valid?

- A. Prescriptions, referrals and recommendations must be updated annually.

Q52. Are we to assume students enrolling in the district with a current IEP for speech therapy have already been referred by a doctor for services?

- A. No, there must be a written referral for speech therapy in the Medi-Cal eligible student's file for Medi-Cal to reimburse the LEA for speech therapy. In order to rely on another LEA's physician referral for speech therapy services, your LEA must maintain the referral documentation in the student's files, and have this information readily available for State and/or Federal review.

VI. Supervision Requirements

Q53. Can a certified public health nurse employed by an LEA supervise licensed vocational nurses (LVNs) and trained health care aides?

- A. No, LVNs and trained health care aides providing specialized health care services must be supervised by a licensed physician, registered credentialed school nurse or certified public health nurse employed by the State Department of Health Care Service. Although a certified public health nurse may be employed by an LEA to provide specialized physical health care services, that public health nurse is not qualified to supervise LVNs or trained health care aides who provide specialized health care services.

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Q54. Has there been recent legislation that changes the supervision requirements for credentialed speech-language pathologists? If so, when is this effective?

- A. Assembly Bill 2837, signed by Governor Schwarzenegger on September 28, 2006, became law immediately pending a provision for confirmation by the California Attorney General. On November 30, 2006, Attorney General Opinion #06-1011 affirmed AB 2837's provisions that a two-tier credential in Speech-Language Pathology (SLP) aligned to the American Speech Language Hearing Association's (ASHA) Certificate of Clinical Competence and satisfies federal Medicaid personnel standards for speech-language pathologists. Pending approval by CMS on a State Plan Amendment (SPA) that will implement the law for Medi-Cal billing purposes, SLPs who hold a valid Commission on Teacher Credentialing (CTC) new "Preliminary SLP Services Credential" or new "Professional Clear SLP Services Credential" will be able to bill for services under the LEA Medi-Cal Billing Option Program without being supervised by a licensed SLP. This change is not currently effective; LEA providers will be notified via a provider bulletin once the SPA is approved and they are able to bill under the new credentialing standards.

Q55. My LEA has a credentialed speech-language pathologist with 20 years of experience. Does the licensed speech-language pathologist still have to supervise this practitioner? What kind of supervision is required?

- A. Yes. Regardless of the years of experience a credentialed speech-language pathologist may have, he or she must be supervised by a licensed practitioner. However, note the answer to the question above, which may allow credentialed speech-language pathologists with the new CTC credentials to bill without being supervised in the future. Refer to the LEA Medi-Cal Billing Option Program Provider Manual located server for supervision requirements.

Q56. My LEA has several credentialed speech language pathologists (SLPs) being supervised by licensed SLPs. What exactly are the supervision requirements?

- A. The supervising licensed practitioner must see each student at least once, have some input into the type of care provided, and review the student after treatment has begun. The supervising licensed speech-language pathologist should periodically: observe assessments, evaluation and therapy; observe the preparation and planning activities; review student records; and monitor and evaluate assessment and treatment decisions of the credentialed speech-language pathologist. Supervision should be appropriate to the level of experience of the credentialed practitioner. These supervision requirements are also applicable to credentialed audiologists, who must be supervised by licensed audiologists.

Q57. If a district only has credentialed speech-language pathologists (SLPs), can they use the licensed SLPs from their SELPA as their supervisor?

- A. Yes. A credentialed SLP requires supervision by a licensed speech-language pathologist to provide speech therapy services. As long as the supervising licensed speech-language pathologist meets the supervision requirements and duties, specified in the LEA Medi-Cal Billing Option Provider Manual located server page 4, there is no requirement that the licensed speech-language pathologist be employed by the LEA.

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Q58. If a district does not have a credentialed school nurse to provide supervision, can the LEA bill Medi-Cal for services provided by LVNs and health aides?

- A. In order for LEAs to bill Medi-Cal for LEA treatment services provided by LVNs and trained health care aides, these practitioners must be supervised by a licensed physician, registered credentialed school nurse, or certified public health nurse employed by the State Department of Health Care Service. In addition, the only type of nurse that is able to bill Medi-Cal for LEA nursing assessments is a credentialed school nurse. Therefore, a registered nurse (RN), certified public health nurse (CPHN) or certified nurse practitioner (CNP) who does not have a valid school nurse services credential may not bill Medi-Cal for LEA nursing assessments. For nursing treatment services, RNs, CPHNs and CNPs who are not also credentialed school nurses require supervision by a credentialed school nurse in order to bill Medi-Cal for services provided. Refer to LEA Medi-Cal Billing Option Provider Manual loc ed serv nurs and loc ed bil (pages 6-7) for additional information.

VII. Free Care and Other Health Coverage

Q59. Can vision and hearing screenings mandated during the statewide periodicity schedule be billed to Medi-Cal?

- A. State mandated screenings (including vision, hearing and scoliosis testing) may never be billed to Medi-Cal.

Q60. Does my LEA need to pursue Other Health Coverage (OHC) prior to billing Medi-Cal for both IEP and non-IEP students?

- A. Yes. For services authorized in a student's IEP/IFSP, Medi-Cal is still the "payer of last resort" to the student's private third party insurance coverage. If an IEP/IFSP student has third party insurance, your LEA must pursue OHC prior to billing Medi-Cal. For services not authorized in the student's IEP/IFSP, or for students without an IEP/IFSP, your LEA must additionally meet all Free Care requirements before billing Medi-Cal. This would include establishing a fee schedule, obtaining third party insurance information for the entire population receiving the service (Medi-Cal and non-Medi-Cal students), and billing OHC prior to billing Medi-Cal. Refer to the LEA Medi-Cal Billing Option Provider Manual loc ed bil (page 2) for Free Care requirements.

Q61. My LEA provides IDEA services to a student with OHC. Do I need individual parental consent to bill OHC, prior to billing Medi-Cal?

- A. Although there is language in the Medi-Cal Application that assigns third party recovery to the State, this agreement is between the beneficiary and the State of California. The LEA is not part of this agreement, and must obtain separate parental consent to bill OHC prior to billing Medi-Cal.

Q62. How can my LEA find out whether a student has Other Health Coverage (OHC)?

- A. OHC information is available through the eligibility tape match.

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Q63. If an IEP/IFSP student receives an additional vision assessment outside of the State mandated vision assessment schedule, will that supplementary vision assessment be reimbursed through the LEA Program?

- A. LEAs may only bill additional vision assessments outside of the mandated schedule for an IEP/IFSP student as part of a health assessment. One initial/triennial IEP/IFSP health assessment is billable every third fiscal year. In the intervening year, an annual health assessment may be conducted. One amended assessment may be billed each fiscal year in which an initial, triennial or annual assessment is conducted. The supplementary vision assessment may be conducted as part of the initial/triennial, annual, or amended assessment, but is not separately billable.

Q64. What is the difference between the Free Care requirement and the Third Party Liability (TPL) requirement?

- A. The Free Care requirement and the TPL requirement are separate, yet interrelated requirements. The Free Care requirement is based on the basic premise that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free Care, or services provided without charge, are services for which there is no beneficiary liability and for which there is no Medicaid liability. In order for the services not to be considered “free”, the following conditions must be met:
- A fee schedule is established for the services provided (this can be a sliding scale to accommodate individuals with low income);
 - The LEA has determined whether every individual served has any third-party benefits (other health coverage), and
 - The LEA bills the beneficiary and/or any third parties for reimbursable services.

For purposes of the provision of school-based health services, there are two exceptions to the Free Care rule: (1) Medicaid-covered services provided as part of an IEP/IFSP, and (2) services provided by Title V of the Social Security Act (Title V of the Act is the Maternal and Child Health Services Block Grant).

The TPL requirement is based on the basic premise that under Medicaid law and regulations, Medicaid is generally the payer of last resort. For this reason, even if services provided as part of an IEP/IFSP are exempt from the Free Care rule, they are not exempt from the TPL requirement. If any student (including those with an IEP/IFSP) has Other Health Coverage (OHC), those third party insurers must be billed prior to billing Medi-Cal for the service.

For more information on the Free Care rule or the TPL requirement, refer to the 1997 Medicaid and School Health: A Technical Assistance Guide, posted on the LEA Program website at <http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>.

Q65. To meet the Free Care and Other Health Coverage (OHC) requirements, can an LEA bill a claim to Medi-Cal after billing OHC, but before it has been processed by OHC?

- A. No, your LEA must receive a valid denial of non-coverage from OHC prior to billing Medi-Cal. The CMS' Medicaid and School Health: A Technical Assistance Guide (1997) provides additional guidance regarding OHC requirements. This document is available on the LEA Program website at <http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>.

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Q66. Can my LEA bill for services rendered to non-IEP students if one parent refuses to provide Other Health Coverage (OHC) information?

- A. No, if one parent refuses to provide OHC information, the care is considered “free” and cannot be billed to Medi-Cal. Refer to the LEA Medi-Cal Billing Option Provider Manual located bil (page 2) for Free Care requirements.

Q67. If a non-IEP/IFSP child is referred for a vision assessment outside of the State mandated periodicity schedule, can Medi-Cal be billed?

- A. If the vision assessment is not provided on the State mandated periodicity schedule, it may qualify for Medi-Cal reimbursement if the Free Care requirements are met.

VIII. Contracted Practitioners

Q68. My school district is part of an LEA collaborative that bills under one provider number and shares a school nurse. My school district is responsible for paying the salary and benefit expenses of the nurse. The remaining member school districts in the collaborative contract for this nurse’s services. Given this situation, can all collaborative members still bill for the nurse’s services under one provider number?

- A. Yes. Since LEAs participating in a billing collaborative are all billing under a single Medi-Cal provider number, collaborative members may bill for services provided by an employee of one of the collaborative members, regardless of which school district in the collaborative employs the practitioner.

Q69. Small districts may not be able to employ multiple providers (e.g., RN, speech therapists, psychologists, etc.) to provide health services. If the district employs only one type of practitioner (such as a credentialed school nurse), can it contract for other types of practitioners (such as speech therapists) and bill for services provided by these contracted practitioners?

- A. The school district can contract with another enrolled LEA provider to provide services to Medi-Cal eligible students. Under this scenario, however, the enrolled LEA provider employing the practitioners will bill Medi-Cal for the services. The school district may also contract with additional health professionals to supplement health services that are being provided by its employed health staff. In order for the school district to bill Medi-Cal, the service provided by the contracted health professionals must be the same services that the school health employees provide.

**LEA Medi-Cal Billing Option Program
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IX. Rendering Practitioner Qualifications

- Q70. If one of my special education teachers has the educational and credentialing requirements of a direct-care practitioner, can I bill Medi-Cal for direct health services provided by this person? For example, can my special education teacher who meets the requirements of a Program Specialist bill for Targeted Case Management (TCM) services?**
- A. The job title does not need to match the LEA qualified rendering practitioner title, so long as the person providing a direct health service meets the educational and program credentialing requirements for billing under the LEA Medi-Cal Billing Option. In this example, your LEA may bill for TCM services rendered by a special education teacher who meets the qualifications of a Program Specialist.
- Q71. Are services provided by occupational therapy assistants, speech therapy assistants or physical therapy assistants reimbursable under the LEA Program?**
- A. No, therapy assistants are currently not qualified practitioners under the LEA Program.
- Q72. Can a school district bill for psychology/counseling services provided by a graduate student who is supervised by a licensed and/or credentialed psychologist, social worker or counselor?**
- A. No. Psychology/counseling services provided by graduate students are not billable under the LEA Program. Qualified practitioners who may provide psychology/counseling services can be found in LEA Medi-Cal Billing Option Provider Manual loc ed bil pages 6 and 7 and loc ed serv psych page 2.
- Q73. What are the licensing and credentialing requirements for non-public school and agency providers?**
- A. Contracted licensed clinical social workers, licensed psychologists, licensed educational psychologists, and licensed marriage and family therapists employed by non-public schools and agencies must hold a valid license or hold a valid pupil personnel services credential in order to bill Medi-Cal for services. Refer to the LEA Medi-Cal Billing Option Provider Manual loc ed rend for specific rendering practitioner qualifications.

X. Targeted Case Management (TCM) Policy and Billing

In December 2007, CMS published an interim final regulation (CMS-2237-IFC) clarifying Medicaid reimbursable targeted case management services. The impact of the CMS interim regulations on the LEA Program is yet to be determined. DHCS policy and clarification will be forthcoming, once the interim rule is finalized and published.

LEA Medi-Cal Billing Option Program Frequently Asked Questions (FAQs)

Q74. How often does my LEA have to submit the TCM Labor Survey in order to bill for TCM services? Do TCM services need to be in the IEP?

- A. You must complete the Labor Survey only once, prior to billing for TCM services. The Labor Survey is available for download on the LEA Program Website. TCM is only billable for IEP/IFSP students, and must be authorized in the IEP/IFSP.

Q75. Can my LEA bill Medi-Cal Administrative Activities through the MAA Program and LEA TCM services?

- A. There is some overlap between Medi-Cal Administrative Activities through the MAA Program and LEA TCM services. Regardless of whether you bill Medi-Cal Administrative Activities through the MAA Program or TCM services through the LEA Program, you may not bill more than once for the same service. If your LEA is billing Medi-Cal Administrative Activities through the MAA Program, please refer to the California School-Based Medi-Cal Administrative Activities Manual, Section 5 (available at www.dhs.ca.gov/maa/webpages-section-units), for direction on how to account for time spent by case managers who are also participating in the LEA Medi-Cal Billing Option Program.

Q76. Can a student have multiple case managers for TCM services and bill Medi-Cal? We are in a rural area and follow multiple problems for families. The nurse may go out one day and help the family find housing. The psychologist may go out and help the family find mental health services for a family member.

- A. Medi-Cal recipients can be assigned more than one case manager. According to the LEA Medi-Cal Billing Option Provider Manual located on page 3, "The California Department of Health Care Services (DHCS) recommends that each Medi-Cal recipient be assigned to one case manager who has the ability to provide recipients with comprehensive TCM services." However, Medi-Cal practitioners in some schools have distinct areas of expertise, and in these cases, it may be necessary to have more than one case manager. When more than one case manager provides TCM services the LEA must avoid duplication of services when billing for the services. In order to do this the LEA must:
- (1) clearly document the LEA and TCM services rendered by each TCM agency or provider, and (2) where necessary, enter into written agreements defining the case management services each agency and/or provider will be responsible for rendering. LEAs may only bill for TCM services when rendered by TCM providers identified in the LEA Medi-Cal Billing Option Provider Manual located on page 7.

XI. Transportation Policy and Billing

In December 2007, CMS issued final rule 2287 (CMS-2287-F) eliminating Medicaid Administrative Claiming and Medicaid claiming for transportation of school-aged children between home and school. Implementation of LEA Medi-Cal Billing Option Program changes related to transportation will impact LEAs in SFY 2008-09 and DHCS policy and clarification will be published in upcoming provider bulletins, provider manual replacement pages and on the LEA Program website.

**LEA Medi-Cal Billing Option Program
Frequently Asked Questions (FAQs)**

Q77. Can we bill for transportation to/from a covered service that we are not claiming? For example, the student is being transported to the County Office of Education (COE) for physical therapy service, which is authorized in the IEP. The COE is claiming for the physical therapy service.

- A. If the child is receiving a covered service on the same day he or she is transported, and both the service and the transportation are authorized in the student's IEP, your LEA may bill for the transportation even if another provider is responsible for billing the covered service. If an LEA bills only for transportation, they should maintain documentation that another covered service was provided on that day at a different venue.

Q78. In order to bill Medi-Cal for non-emergency medical transportation services provided in a wheelchair van, must students be wheelchair-bound?

- A. Yes, under current regulations, in order to bill Medi-Cal for students being transported in a wheelchair van, the student must be transported in a wheelchair.

Q79. Can I only bill for mileage under the LEA Program?

- A. No, you cannot bill Medi-Cal for mileage without also billing for the corresponding "flat-rate" transportation. However, you may still bill for allowable non-emergency transportation under the "flat-rate" without billing mileage.

Q80. Can an LEA provider be reimbursed for transportation to special education Medi-Cal eligible students who are given medication on a daily basis at school?

- A. For an LEA provider to be reimbursed for transportation, a Medi-Cal eligible student must receive a Medicaid covered service on the date of transport and both the transportation and Medicaid covered service must be included in the student's IEP. If dispensing medication to a student does not meet the seven continuous minutes of nursing treatment, it is not considered a Medicaid covered service under the LEA Medi-Cal Billing Option Program. (Title 22, CCR, Sections 51360 and 51535.5)

XII. Documentation and Records Retention Requirements

Q81. For documentation purposes, is it acceptable for my LEA to present scanned documentation, or must all documentation be presented for State or federal review in its original hard-copy form?

- A. No, LEAs must maintain original hard-copy supporting documentation for services rendered for at least three years from the date of service.

Q82. Do we need to distinguish the documentation we maintain for educational purposes versus the documentation for Medi-Cal?

- A. Yes. All services rendered and billed to Medi-Cal must meet federal, State and program documentation requirements. Documentation for educational purposes may not fulfill these requirements.

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Q83. For an IEP/IFSP student, where should written prescriptions, referrals and recommendations be maintained?

- A. For IEP/IFSP students, written prescriptions, referrals, and recommendations can be documented in the student's IEP/IFSP or included as an addendum to the IEP/IFSP. A request for assessment by a parent, teacher, or school nurse must be maintained in the student's files. If your LEA currently uses a physician-based standards protocol to meet the State requirement for speech and audiology treatment referrals, a copy of the protocol cover letter must be kept in the student's files.

Q84. Does each service encounter need to be documented with progress notes/ documentation of services?

- A. Yes, CMS's Medicaid and School Health: A Technical Assistance Guide (August 1997) indicates that documentation should be maintained on a service-specific basis. In addition, documentation must be created at or near the time of service.

Q85. If the IEP assessment spans several days, what date should be documented for purposes of billing Medi-Cal?

- A. When billing Medi-Cal for an assessment that takes multiple days to complete, use the "from-through" billing method to record the dates over which the assessment was conducted.

Q86. What is required for documenting treatment services?

- A. Practitioners should write case/progress notes each time the student is treated and save those notes in the student's file. Each service should be documented with the student's name, date of service, practitioner type, and signature. Notes made documenting the service should be consistent with the practitioner's professional standards.

Q87. Can licensing and credentialing documentation for practitioners be kept in the LEAs central files?

- A. Documentation of licensing and credentialing of practitioners must be accessible for review by State and/or federal agencies. They may be maintained in your central files as long as they are accessible for audit or review.

Q88. How long are we required to retain documentation? Does this time period change if you are under investigation?

- A. You must maintain all documentation supporting services rendered for at least three years from the date of service. If your LEA is involved in an audit, review or investigation, all documentation for the audit/review/investigation period must be maintained until the issue is completely resolved. This may mean documentation is retained beyond the three year minimum.

Q89. Are we required to maintain documentation of services provided after the student leaves the LEA?

- A. If a student leaves your LEA, you must maintain documentation of services in accordance with the three year minimum retention timeline.

**LEA Medi-Cal Billing Option Program
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Q90. *How long should my LEA retain documents related to the CRCS?*

- A. *Original hard-copy supporting documentation must be maintained until the auditing process for your LEA Medi-Cal Billing Option CRCS has been completed. In accordance with W&I Code Section 14170, please retain both your LEA's financial and medical records for three years from the date of submission of your CRCS forms.*

XIII. Units of Service and Reimbursement Rates

Q91. Are report writing and other indirect service time accounted for in the new rates?

- A. Yes, the new rates account for indirect service costs associated with the direct provision of health services. Your LEA should only bill for direct service time.

Q92. I don't understand why I need to record the number of units (e.g., one, two or three units) for 15-45 minute initial treatment services when this whole time period is reimbursed at the same rate, regardless of the number of units?

- A. It is imperative that you accurately record the units of initial service, as the units billed to Medi-Cal will be used in the Cost and Reimbursement Comparison Schedule to calculate your LEA's cost to provide services. For initial treatment services billed in 15-45 minute sessions, bill one unit for 15 completed minutes, two units for 30 completed minutes and three units for 45 completed minutes.

Q93. Can we bill LEA, MAA, or both for the time it takes to prepare reports?

- A. LEAs may not bill under the LEA Program for report writing. You may only bill for direct service time. Preparation of reports, travel time and other administrative activities that are related to the direct provision of health services are not claimable under the LEA Program, as this time was factored into the new LEA interim rate structure. Billing for indirect time would be "double-dipping". In addition, report writing cannot be billed under MAA. For a single service, you may bill either MAA or LEA, but not both.

Q94. For each LEA reimbursable service, Medi-Cal maximum allowable rates are listed in the LEA Medi-Cal Billing Option Provider Manual located bil cd. Will we be reimbursed at the Medi-Cal maximum allowable rate?

- A. No. You will be reimbursed the Medi-Cal maximum allowable rate multiplied by the federal medical assistance percentage (FMAP), which is currently 61.59%. Note that the FMAP percentage can fluctuate slightly from year to year.

Q95. Are LEA claims subject to timeliness cutbacks if claims are submitted 6 months after the date of service?

- A. No. Assembly Bill 2950 eliminates timeliness cutbacks for LEA claims submitted for reimbursement between the seventh and twelfth month after the month of service. LEA claims were previously subject to reduced reimbursement of 75 and 50 percent of payable amount if submitted beyond six months. Effective for dates of service on or after January 1, 2007, LEA claims may be reimbursable within twelve months of the month of service. LEA claims submitted after the twelfth month of service without a legitimate delay reason code will continue to be denied.

**LEA Medi-Cal Billing Option Program
Frequently Asked Questions (FAQs)**

XIV. Claim Form Completion

Q96. When completing a claim, is there a specific order in which the modifiers should be recorded?

- A. The type of service, practitioner type and IEP/IFSP modifiers can be listed in any order; however the appropriate HCPCS/CPT procedure code must be listed first. When entering modifiers, do not include hyphens or spaces. More detailed information is available in the local billing and submission sections of the LEA Medi-Cal Billing Option Provider Manual.

Q97. Can you bill more than one service on a single claim form per student?

- A. Yes, the procedure codes and modifiers will differentiate the services provided, as well as the rendering practitioner, if applicable.

Q98. For “from-through billing”, do the dates of service have to be consecutive?

- A. No, the dates do not need to be consecutive, but you can only bill one type of service per “from-through” claim line.

Q99. Where can LEA providers get the ICD-9 codes for the diagnosis code box on the claim form?

- A. LEA providers may obtain the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9) code book from:

Ingenix
P. O. Box 27116
Salt Lake City, UT 84127-0116
1-800-INGENIX (464-3649), 1-800-765-6588 (Customer Service), or

PMIC (Practice Management Information Corporation)
Order Processing Department
4727 Wilshire Blvd., Suite 300
Los Angeles, CA 90010-3894
1-800-MED-SHOP (633-7467) Monday-Friday 8:30 a.m. – 5:00 p.m. (CST)

Q100. Is there an LEA-specific ICD-9 code that should be used on all LEA claims?

- A. No. The ICD-9 diagnosis code should be appropriate to the medical diagnosis or covered service the student receives to support the service. Current Medi-Cal policy requires providers to bill using the highest level of ICD-9-CM diagnosis code available on a given date of service. Effective January 1, 2005, claims billed with an invalid diagnosis code will be returned. The code must provide the highest level of specificity available in order to be valid. For example, if a provider bills with a 3-digit diagnosis code when a 4-digit or 5-digit diagnosis code is available, the 3-digit code is considered invalid and the claim will be returned. This policy does not apply to medical transportation claims.

**LEA Medi-Cal Billing Option Program
Frequently Asked Questions (FAQs)**

Q101. How long does it take for EDS to process a claim?

- A. Electronic claims are generally processed in seven to 10 days; clean hardcopy claims are generally processed within 30 days of submission.